DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	
	155334		B. WIN	G		06/14/2	U11
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
				l	16TH ST		
KINDREL	) TRANSITIONAL C	CARE AND REHAB-WILDWOOD		INDIAN	APOLIS, IN46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Life Sefety Co.	do Pagartification and	l vo	0000			
	_ <del>-</del>	de Recertification and	K	1000			
		Survey was conducted by					
		Department of Health in					
	accordance with	42 CFR 483.70(a).					
	Survey Date: 06	/14/11					
	Facility Number:						
	Provider Number						
	AIM Number: 10	00267520					
	Surveyor: Mark Caraher, Life Safety						
	Code Specialist						
		ty Code survey, Kindred					
		e and Rehab-Wildwood					
	was found not in	compliance with					
	Requirements for Participation in						
	Medicare/Medica	aid, 42 CFR Subpart					
	483.70(a), Life Safety from Fire and the						
	2000 Edition of the National Fire						
		iation (NFPA) 101, Life					
		C), Chapter 19, Existing					
	· ·	upancies and 410 IAC					
	16.2.	upuncies und 710 IAC					
	10.4.						
	This one story far	cility was determined to					
	<u>-</u>	_					
		1) construction and was					
		The facility has a fire					
	alarm system with smoke detection in the						
		as not separated from the					
	corridor. The fac	cility has a capacity of					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 93SB21 Facility ID: 000227

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
15533		155334	B. WINC			06/14/20	011
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			7301 E	DDRESS, CITY, STATE, ZIP CODE  16TH ST  APOLIS, IN46219			
			,				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID  PROVIDER'S PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	· ·	LSC IDENTIFYING INFORMATION)	'	TAG	CROSS-REFERENCED TO THE APPROPRIATE		DATE
		nsus of 126 at the time of					BillE
		iisus of 120 at the time of					
	this survey.						
Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/15/11.							
	The facility was	found not in compliance					
	The facility was found not in compliance with the aforementioned regulatory						
	requirements as evidenced by the						
	following:	evidenced by the					
K0038 SS=E	readily accessible with section 7.1.  Based on observe facility failed to egress through 2 locks was readily staff and visitors Egress Locks, sadelayed egress lobe installed on doordinary hazard oprotected through supervised autoninstalled in accordinate or an approved, sprinkler system with Section 9.7, Chapters 12 through the control of the contro	anged so that exits are at all times in accordance 19.2.1 ation and interview, the ensure the means of of 11 delayed egress accessible for residents, LSC 7.2.1.6.1, Delayed ys approved, listed, ocks shall be permitted to cors serving low and contents in buildings thout by an approved, natic fire detection system dance with Section 9.6, supervised automatic installed in accordance and where permitted in ugh 42, provided that: lock upon actuation of an vised automatic sprinkler	K0	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.It is the practice of this center to assure that all exits remain accessable and discharge to an area of safe refuge at all times to include: the ambulance exit door and the exit		07/11/2011	

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	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	(X2) MULTIPLE CO	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 06/14/2011		
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE  7301 E 16TH ST INDIANAPOLIS, IN46219				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION		
	Section 9.7, or upheat detectors of an apartomatic fire design automatic fire design accordance with the lock within 1 application of a frequired in 7.2.1 required to exceed be continuously seconds. The initiation of the lock has been relief force to the result of force to t	lock upon loss of power ock or locking  le process shall release 5 seconds upon force to the release device 5.4 that shall not be ed 15 lbf nor required to applied for more than 3 tiation of the release ivate an audible signal in e door. Once the door eased by the application leasing device, relocking		door by the maintenance of Signs have been affixed to doors that say "push until a sounds door can be opened seconds".II. How other rest having the potential to be a by the same deficient practice identified and what corraction(s) will be taken.All residents have the potential affected by not having sign the exit door that says the can be opened within 15 so of the application of force to the door. All exits were instolensure compliance by 7/11/2011.III. What measure be put into place or what so changes will be made to enthat the deficient practice of not recur. The Maintenance director will inspect exit accurately and add to the preventing and add to the preventing and the practice will not recur, i.e., quality assurance program put into place. The preventing maintenance log will be resulted by the PI committee monthensure continued compliatione year then quarterly the	the alarm d in 15 sidents affected tice will ective al to be tage on door econds o open spected tres will ystemic nsure does ecess ventive the efficient what will be ve viewed ally to nce for		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		i i	(X2) MULTIPLE C		(X3) DATE SURVEY  COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155334			A. BUILDING	01	06/14/2011
100001			B. WING	A DDDEGG CITY CTATE ZID CODE	00/14/2011
NAME OF PROVIDER OR SUPPLIER			I .	ADDRESS, CITY, STATE, ZIP CODE  16TH ST	
KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD				NAPOLIS, IN46219	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
IAG		,	TAG	DEFICIENCE!)	DATE
		ing the ambulance exit			
	and the exit by th	ne maintenance office.			
	Findings include	:			
	Based on observa	ation with the			
		ector during a tour of the			
		30 p.m. to 2:30 p.m. on			
	=	bulance exit door and the			
		naintenance office are			
	each equipped w	ith delayed egress locks			
	which can be ope	ened by the application of			
	force to the relea	se device within 15			
	seconds but each	exit door was not			
	provided with sig	gnage stating the door			
	could be opened	in 15 seconds by pushing			
	on the door. Bas	ed on interview at the			
	time of observati	on, the Maintenance			
	Director acknowledged each exit door is				
		elayed egress locks but			
	each exit door did not have signage				
	stating the door can be opened within 15				
		oplication of force to open			
	the door.				
	2.1.10(1.)				
	3.1-19(b)				
		5			
K0046		g of at least 1½ hour ed in accordance with 7.9.			
SS=F	19.2.9.1.	a in accordance With 1.3.			
	Based on observa	ation, record review and	K0046	What corrective action(s)	will 07/11/2011
	interview; the fac	cility failed to document		be accomplished for those	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155334 06/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7301 E 16TH ST KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD INDIANAPOLIS, IN46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE testing of emergency lighting in residents found to have been affected by the deficient accordance with LSC 7.9 for 3 of 3 practice.It is the practice of this battery operated emergency lights. LSC center to assure that emergency 7.9.3, Periodic Testing of Emergency lighting is provided to maintain compliance at all times to Lighting Equipment, requires a functional include: interval functional testing test be conducted at 30 day intervals and monthly and annual testing of one an annual test to be conducted on every and a half hour duration of the required battery powered emergency three battery operated emergency lighting system for not less than a 1 lights in the facility. The entire facility was inspected for proper ½-hour duration. Equipment shall be emergency lighting by fully operational for the duration of the 7/11/2011.II. How other residents test. Written records of visual inspections having the potential to be affected and tests shall be kept by the owner for by the same deficient practice will be identified and what corrective inspection by the authority having action(s) will be taken. The jurisdiction. This deficient practice could maintenance director will inspect affect all occupants in the facility emergency lighting weekly for one quarter and then monthly including staff, visitors and residents. thereafter. The annual test has been conducted and the monthly Findings include: tests are being performed.III. What measures will be put into Based on observations with the place or what systemic changes will be made to ensure that the Maintenance Director during a tour of the deficient practice does not facility from 12:30 p.m. to 2:30 p.m. on recur.Inspections will be logged 06/14/11, there are three battery operated into the centers preventive emergency lights located in the facility. maintenance log.IV. How the corrective action(s) will be Based on record review with the monitored to ensure the deficient Maintenance Director from 9:30 a.m. to practice will not recur, i.e., what 11:30 a.m. on 06/14/11, documentation of quality assurance program will be thirty day interval functional testing and put into place. The preventive maintenance log will be reviewed annual testing for each battery operated at the monthly PI committee emergency light for at least a 1 ½-hour meeting to ensure continued duration was not available for review. compliance for one year. Based on interview at the time of observation the Maintenance Director

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155334		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/14/2011	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			7301 E	ADDRESS, CITY, STATE, ZIP CODE E 16TH ST NAPOLIS, IN46219	1
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION
	light is tested on acknowledged th available for rev or annual testing	ery operated emergency a monthly basis but here is no documentation iew of thirty day interval for each of the three hemergency lights in the			